Other Document Form

Number D1142

Title DRAFT ADDITIONAL REPORT BY IRENE WATERS SEPT 2004

(Include source and any document number if relevant)

Receivers instructions urgent action Yes (No) LINK TO NOMINAL WATERS

Document registered / indexed as indicated

No(s) of actions raised

Statement readers instructions

Indexed as indicated

No(s) of actions raised

Examined - further action to be taken

Further actions no(s)

Code A

Indexer

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DRAFT ADDITIONAL REPORT

SPECIALIST FIELD:- NURSING CARE

NURSING CARE GIVEN TO AN ADDITIONAL 25 PATIENTS AT GOSPORT WAR MEMORIAL HOSPITAL AND TO REVIEW 6 PATIENTS ADDITIONAL NOTES

REPORT PREPARED BY:- IRENE WATERS LL.M, M.Sc, M.N.,R.H.V., R.G.N.

DATED:- SEPTEMBER 2004

ON THE INSTRUCTIONS OF:-

DETECTIVE CHIEF INSPECTOR NIGEL NIVEN
HAMPSHIRE CONSTABULARY
POLICE HEADQUARTERS
WINCHESTER
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SUBJECT MATTER:-

This report addresses the appropriateness of the nursing care given to another 22 former patients of Gosport War Memorial Hospital who died during the period 1989 and 2001and whether the nursing care fell below a standard that would be expected from reasonably competent nurses. Also included in this report are the additional notes for 6 patients that were included in the first report.

CONTENTS:

This draft report follows on from the first report and therefore Paragraphs 1-5 are the same for both reports. The final version will combine both reports.
The next 25 cases are therefore numbered to follow on from the first report.

Synopsis

Thank you for seeking about the standard and appropriateness of the nursing care given to another 25 former patients of the Gosport War Memorial Hospital, who died from the period of 1989 and also the 6 additional notes from the previous patients.

1. Introduction.

1.01 The writer

I am Irene Waters. My specialist field is nursing and nursing care. I am a registered general nurse and hold a community nursing qualification. I have a Master of Nursing degree and was formerly Director of Nursing, responsible for 1408 nursing staff, with the Bart's NHS Group, this included a general acute Hospital and a Community Health Services Unit. I have worked in Nursing Homes, been part of the inspection process and am a regular panel member for due regard on the Professional Conduct Committee for the Nursing and Midwifery Council NMC. I am currently employed as a clinical and professional adviser, health consultant and expert witness and am a non executive Director of a Primary Care Trust which has a Community Hospital. Full details of my qualifications and experiences are in appendix 1.

6.00 Summary Review of the facts surrounding the care of 25 patients.

6.62. Code A

Date of Birth: Code A Age: **86**
Date of Admission to GWMH: **20th May 1996**
Date and time of Death: **09.50 hours on 31st May 1996**
Cause of Death: **1. (a) Carcinomatosis**
(b) Carcinoma of sigmoid colon
2. Multi infaract dementia. Chronic renal failure

Post Mortem: **yes**
Length of Stay: **11 days**

Code A 's past medical history was noted to be:-

Code A

Code A was born in Southern Ireland and moved to England when she was 20 years old. She was married but her husband died suddenly after the war. They had no children. Code A was a retired clerical worker who lived in her own home. She had a home carer and a good neighbour who did her shopping, washing and cleaning. Mrs Cox had a nephew who was noted as her next of kin. Code A was becoming increasingly confused and not eating. There was some evidence of self-neglect and poor mobility. Code A was admitted to Gosport War Memorial Hospital on 3rd May 1996 but after developing swallowing problems was transferred to Queen Alexandra Hospital on 9th May 1996 for investigations into possible carcinoma. After test results being negative Mrs Cox was transferred back to Gosport War Memorial Hospital on 20th May 1996.

Care plans commenced for total assessment, dietary intake and fluid intake. (page 110/111/112/114) A lifting/handling risk calculator was recorded with a score of 23 recorded. (page 12) When Code A was transferred to Daedalus ward on 29th May 1996 (page 4/5) care plans were commenced for hygiene, catheter, at risk of pressure sores, nasogastric food tube and settle at night. (pages 15/16/17/18/19)
A Barthel ADL index was completed with a score of 1 recorded. (page 10)
A Waterlow was also completed with a score of 18 noted. (page 13)
A nutritional assessment plan also commenced on 29th May 1996 as Mrs Cox was fed via a nasogastric tube. (page 14)

Daily summary

3rd May 1996

Clinical notes – emergency admission with increased confusion, self-neglect and poor mobility. Needs full assistance. (page 13/14/15/16)

7th May 1996

Clinical notes – swallowing problems. (page 17)

9th May 1996

Clinical notes - transfer agreed to Queen Alexandra Hospital. Possible carcinoma. (page 18)

20th May 1996

Transfer form – self-neglect/depression. Poor nutritional and fluid intake. Sacrum red but not broken. (page 49/50)

Clinical notes – transferred back to Gosport War Memorial Hospital, Mulberry Ward. No carcinoma. (page 18)

Nursing notes – transfer back from Queen Alexandra Hospital. Remains on IVI normal saline. Assessed for ECT. Quite cheerful. (page 119)

21st May 1996

Clinical notes – alert, refusing oral fluids and medication. Says she does not want examination and treatment. Moderate dehydration for IV fluids. Very depressed and very confused. Discussed ECT with nephew. Right arm swelling. Dr Banks to review. (page 23)

Nursing notes – IV drip running. Encourage to take sips of drink. (page 119)

22nd May 1996

Clinical notes – slow IV fluids. (page 25)

Nursing notes – restless night – drip would not run through. (page 119) Taken small diet but no fluids. Refused medication. Mood very low. Does not want ECT. Hand/arm noticed to be swelling. Dry draining into tissues arm to be elevated. (page 120/121)

23rd May 1996

Clinical notes – is accepting liquid and porridge says she does not want ECT. Discuss with Dr Banks with hold ECT for moment. (page 25)

Nursing notes – catheter draining. IV running. Full nursing care given. Ate some porridge but refused lunch. (page 122)

24th May 1996

Clinical notes – secondary hypoparthyroidism. Need transfer for long-term investigations. For IV fluids. Chest clear. (page 25)

Nursing notes – full nursing care given. IV continues. Seen by Dr Munroe small amount of blood found on sheet ? from urethra or rectum. (page 122)

26th May 1996

Nursing notes – restless. Food taken but no fluids. (page 123/124)

27th May 1996

Clinical notes – breathing very noisy. Looks dehydrated, mouth very dry. Encourage oral fluids. (page 26)

Nursing notes – breathing noisy. Seen by doctor. Few sips oral fluids but refused diet. (page 124)

28th May 1996

Clinical notes – physically less well despite rehydration. Drowsy, apathetic. Oral intake negligible. Refusing medication. (page 26)

Agreed to NG tube for feeding. ECT treatment might make a difference. No for NG tube at present. Code A refusing ECT treatment. (page 27)

General deterioration over weekend. Refusing food and drink. Withdrawn eyes closed. Not keen ECT. Section 3 and Section 62 Mental Health Act explained to niece fully appreciates this course of action. (page 27/28)

Nursing notes – refusing fluids/diet. Very withdrawn. To be placed under section 3 of the Mental Health Act and section 62 for 2 emergency ECT's.

29th May 1996

Clinical notes – treatment plan and review. Plan for up to 12 ECT treatments bilateral to start with then change to interim? Once eating and drinking. Consider future at home. ? res care with family. (page 28)

Nursing notes – transferred to Daedalus Ward.

Transfer form – low in mood. Not eating or drinking. Pressure areas intact. Immobile at present. All nursing care needed. Nursed on pegasus mattress. (page 4/5)

Summary – Transfer from Mulberry ward after ECT treatment. Commence NG feeding. Further ECT treatment on Friday. Seen by Dr Banks – nil ordered. Slept for short periods. (page 7)

30th May 1996

Clinical notes – ECT required and performed. Issued form to authorise 11 more treatments. (page 29)

Nasogastric feeding continues with pump for ECT tomorrow. (page 29)

Summary – seen by dietician. Tolerating NG feeding. Code A continues to refuse all fluids and diet. Complaining of pain ? heartburn. Oramoph prescribed by duty doctor. 20.40 hours oramorph given 2.5mls with good effect. No further chest pains. (page 7/8)

31st May 1996

Clinical notes – ECT (2nd treatment carried out) at 9.15am. Started breathing after anesthetic about 9.40am. Vomited coffee ground vomit. Aspirated but no response to oxygenation. Certified death at 09.50 hours by anesthetist Dr Page. Nasogastric tube removed after death. Death reported to coroner's office. (page 29)

Summary – transfer to Phoenix Day Hospital for ECT. (page 8)

Comment

Code A was a frail elderly lady of 86 year's old admitted to Gosport War Memorial Hospital with confusion and self neglect. She was transferred to Queen Alexandra Hospital for investigations as she had difficulty swallowing and returned to Gosport War Memorial Hospital on 20th May 1996.

The nursing records show a comprehensive assessment made to identify nursing care needs, this included a nutritional assessment. It showed that she was not able to manage her own care. Risk assessment for manual handling and pressure damage were made.

There is evidence from the records that appropriate care was given.

Code A became increasingly withdrawn, she refused oral nutrition and a Code A She continued to deteriorate and there is evidence that the nursing staff spoke with the family about Code A and kept them informed about her condition.

Code A commenced ECT.

Code A died on 31st May 1996.

In my opinion the standard of nursing care was acceptable in this case and she had good care.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	1A			
Unclear B				
Unexplained by Illness				

6.63. BJC60 Dorothy Stanford

Code A Age: 77

Date of Admission to GWMH: **23rd November 1993**
Date and time of Death: **05.45hours on 27th November 1993**
Cause of Death:
Post Mortem: Cremation
Length of Stay: **4 days**

Mrs Stanford's past medical history:-

: Code A

Mrs Stanford was a widow, she had a daughter and lived in Egremont Rest Home. Mrs Stanford was admitted to Queen Alexandra Hospital via her GP suffering from a left CVA with right hemiplegia. She needed assistance with all activities of daily living. Mrs Stanford was transferred to Gosport War Memorial Hospital on 23rd November 1993. She had been catheterised and was fed via a naso gastric tube. (page 7/8)
On admission a nursing admission form was completed noting that Mrs Stanford was highly dependent and her levels of consciousness varied. (page 10/11/12)
Care plans were completed on admission for NG tube, catheter, hygiene, insulin dependant diabetic and immobility. (pages 18/19/20/21/22)

Daily summary
23rd November 1993
Transfer form – NG tube in situ. Skin intact but dry at times. Referred to physio requires turning in bed and regular mouthcare. Catheterised on 20/11/93. Temperature requires fan therapy. (page 7/8)
Nursing report – transferred from Queen Alexandra Hospital. Seen by Dr Barton. NG tube in situ. (page 5)
24th November 1993
Clinical notes – some improvement in general condition. (page 78)
25th November 1993
Nursing report – refusing fluids. Seen by Dr Barton to **commence syringe driver at 11.50 hours. (page 5)**
26th November 1993
Nursing report – visited by Mrs Hart. To contact solicitors and undertakers if dies before 17.00 hours today. (page 5)
Clinical notes – further deterioration on S/C analgesia.
27th November 1993
Died at 05.45 hours. Pronounced dead by Sister Goldsmith. For cremation. (page 5)

Comment

This lady was admitted to Queen Alexandra Hospital by her GP on23rd November 1993 with a left sided CVA and right hemiplegia. She was transferred to Gosport War Memorial Hospital on 23rd November 1993. A doctor noted that she needed analgesia but it is not clear why. She was noted to have different levels of consciousness, was catheterized and had a nasogastric tube in place. There is no evidence that this lady was experiencing pain or showing any signs of distress.

Diamorphine was commenced on 25th November 1993 by Dr Barton. Mrs Stanford died on 27th November 1993.

Mrs Stanford was frail, she had suffered strokes. Opiates were prescribed and administered without any obvious need. There was no clear reason for her death.

Operation Rochester. **Clinical Team's Assessment Form**				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B		2B		
Unexplained by Illness				

6.64. BJC61 Code A

Code A Age: **69**

Date of Admission to GWMH: **9th April 1997**
Date and time of Death: **06.10hours on 16th February 1999**
Cause of Death:
Post Mortem:
Length of Stay: **22 months**

Mr Code A past medical history:-

Code A

Mr Code A lived with his wife. They had a daughter who lived in Australia. Mr Code A was allergic to shellfish. In February 1997 Mr Willis suffered a dense left side hemiparesis and was admitted to the Queen Alexander Hospital as an emergency admission via his GP. Mr Willis underwent an insertion of a PEG tube in March and April 1997. He was transferred to Gosport War Memorial Hospital on 9th April 1997. In letters in August 1998 and September 1998 it was noted that Mr Code A was to have continuing care on Daedalus ward and was not eligible for a Nursing Home. It was also noted that he was MRSA positive. (page 12/16/15/17)
On admission regular Waterlow and Barthel scores were recorded as well as nutritional assessments and handling assessment and evaluations were recorded. A number of care plans were completed on admission, and throughout Mr Code A long stay, for PEG tube, catheter, hygiene, MRSA, constipation, shoulder pain, sleep, pressure sore right heel, pressure care left ankle, swollen scrotum and broken areas, diabetes, pain and left sided weakness.

Daily summary
9th April 1997
Transfer form – transferred from Queen Alexandra Hospital. Suffered a right intra cerebral bleed on 11/3/97. PEG[1] inserted 4/4/97 to supplement oral intake of soft diet and thickened fluids. Appetite very poor since CVA. Catheter insitu. Some constipation. Two pressure areas on back and sacrum. Nursed on Pegasus mattress. MRSA+ during hospital stay in nose/throat/anxillas/catheter and wound sites. This is being treated. Wife aware of transfer. (page 105/106/107)
1st May 1997
Contact record – seen by Dr Lord. Ask infection control if discharge is possible to Nursing Home if MRSA positive. (page 120)
2nd May 1997
Contact record – can be discharged if remains MRSA +. (page 120)

13th May 1997
Contact record – diarrhoea for 3 days. (page 120)
22nd May 1997
Contact record – multidisciplinary team meeting. Continues with modified feeds. Transfer to continuing care bed. Wife to obtain power of attorney. (page 121)
27th May 1997
Contact record – infection control last set of swabs clear. Stop treatment. (page 121)
2nd June 1997
Contact record – seen by Dr Lord. Generally improved over last two weeks. (page 122)
6th June 1997
Contact record – still MRSA + in throat. Commence treatment again. (page 122)
12th June 1997
Contact record – seen by Dr Lord moved to slow stream stroke bed. Continue with physio. Seen by dietician. (page 122)
24th June 1997
Contact record – general situation discussed with wife. (page 123)
25th June 1997
Contact record – MRSA + throat and catheter treatment to recommence. (page 124)
10th July 1997
Contact record – seen by Dr Lord to transfer back to continuing care bed. Will stay until MRSA negative. (page 124)
28th July 1997
Contact record – seen by Dr Lord wife present. She has seen and likes Tudor Lodge Nursing Home. Plan for discharge when clear of MRSA. (page 125)
8th August 1997
Contact record – complaining of pain and requesting increase in analgesia. (page 125)
10th August 1997
Contact record – **found on floor**. Accident form completed. Banged head. Doctor informed. (page 125)
19th August 1997
Contact record – **foaming** at mouth. Doctor informed. (page 126/126)
28th August 1997
Contact record – MRSA negative.
29th August 1997
Contact record – MRSA positive.
25th September 1997
Contact record – Catheter washout. **Rigors**. Seen by Dr Lord. (page 128)
10th October 1997
Contact record – positive MRSA nose and throat. Treatment commenced. (page 128)

1st November 1997
Contact record – **frothing at mouth**. (page 129)
10th November 1997
Contact record – right groin positive MRSA on 3/11 negative nose and throat. (page 129)
27th November 1997
Contact record – MRSA negative. (page 129)
1st December 1997
Contact record – seem by Dr Lord refer to OT for assessment **for discharge to Nursing home in January 1998**. (page 129)
2nd December 1997
Contact record – increasingly restless at night. Sleeping very little. Uncomplaining regarding pain. (page 129)
5th December 1997
Contact record – swab taken. MRSA + on axilla. Continue treatment regime. (page 129)
19th December 1997
Contact record – MRSA negative. (page 129)
21st December 1997
Contact record – frothing at mouth. (page 129)
29th December 1997
Contact record – MRSA negative. (page 130)
12th January 1998
Contact record – seen by Dr Lord for discharge. Refer to social services. (page 131)
23rd January 1998
Contact record – MRSA negative. (page 131)
27th January 1998
Contact record – message received from social worker. May be difficult to place due to having MRSA. (page 131)
3rd February 1998
Contact record –MRSA+ in throat. (page 132)
9th February 1998
Contact record – Seen by Dr Lord social services referral to be followed up. (page 132)
11th February 1998
Contact record – health summary and OT assessment sent. (page 132)
23rd February 1998
Contact record – seen by Dr Lord **suspend discharge** for 1 month then review. (page 132)
9th March 1998
Contact record – seen by Dr Lord to discontinue MRSA treatment for 2 months. To remain here for this period. (page 133)

20th April 1998
Contact record – continue until MRSA status reviewed. (page 134/135)
23rd April 1998
Contact record – social services file closed. (page 134/135)
15th May 1998
Contact record – MRSA + throat. (page 134/135)
5th June 1998
Contact record – confused/apyrexial. (page 134/135)
9th June 1998
Contact record – MST increased to 20mg. (page 134/135)
15th June 1998
Contact record – seen by Dr Lord medical condition stable. Now ready for discharge to Nursing home refer to social services. (page 134/135)
25th June 1998
Contact record – wife to look for nursing home. (page 135)
29th June 1998
Contact record – seen by Dr Lord. Happy for Norman to stay until placement found. (page 136)
14th July 1998
Contact record – spoke to Tudor Lodge Nursing Home aware PEG feed and MRSA positive and smokes. Happy to have. (page 136)
23rd July 1998
Contact record – discharge discussed. (page 136)
29th July 1998
Contact record – Nursing home to accept when social services funding agreed. (page 136)
5th August 1998
Contact record – Nursing home unable to take due to being unable to cope with his needs. (page 137)
21st August 1998
Contact record – scrotum swollen and causing distress. **MST increased** to 30mg. (page 137)
27th August 1998
Contact record – **MST increased to 50mg**. (page 137)
30th August 1998
Contact record – vomited +++. (page 137)
4th September 1998
Contact record – very distressed and crying. **Complaining of pain** across lower pelvic area. Given oramorph 10mg with good effect. (page 138/139)
10th September 1998
Contact record – very distressed complaining of pain returned to bed. Oramorph 10mg given. (page 138/139)

18th September 1998
Contact record – tried to stand fell to floor. No injuries accident form completed. (page 140)
21st September 1998
Contact record – seen by Dr Lord referred for replacement of PEG feed. (page 140)
25th September 1998
Contact record – seen by Dr Barratt blisters on right foot. 2 more broken areas. Swabbed. Do daily blister count. (page 140)
28th September 1998
Contact record – Dr Barratt notified of increase of blisters. (page 140)
29th September 1998
Contact record – itching causing agitation and discomfort. (page 140)
1st October 1998
Contact record – MRSA + (page 140)
5th October 1998
Contact record – seen by Dr Lord to commence steroids. Stop MST. **Diamorphine via syringe driver**. Photograph blisters. **80mg diamorphine commenced. (page 141)**
7th October 1998
Contact record – daughter informed of condition. (page 142)
11th October 1998
Contact record – **syringe driver renewed**. (page 142)
21st October 1998
Contact record – commence **fentanyl patches**. **Syringe driver discontinued**. (page 142)
22nd October 1998
Contact record – **fentanyl patch found on floor. MST 50mg prescribed.** (page 142)
24th November 1998
Contact record – **oramorph given 10mgs**. (page 143/144)
31st December 1998
Contact record – PEG replaced at Haslar. (page 145)
8th January 1999
Contact record – syringe driver completed 24-hour dose. Skin improved does not appear itchy. PEG fell out reintroduced. (page 146)
10th January 1999
Contact record – catheter found to be out. Recatheterised. (page 146)
11th January 1999
Clinical notes – prognosis poor. Keep comfortable. PEG tubes come out ? pulled out replaced at Nursing Home. No new blisters. (page 93)
25th January 1999
Clinical notes – blisters left heel now ulcerated. Much better in himself. **Pain reasonably controlled**. Continue NHS C/C. (page 94)

1st February 1999
Contact record – **in severe pain and distress. Syringe driver 100mg diamorphine.** (page 147)
2nd February 1999
Clinical notes – deteriorating. (page 94)
3rd February 1999
Contact record – reported to be in pain. **Diamorphine increased to 120mg**. Appears comfortable and pain free. (page 147)
7th February 1999
Contact record – **continue to be in pain + on movement**. **Syringe driver x 2 dimorphine 200mgs.** (page 147)
8th February 1999
Clinical notes – very distressed and calling out. Very little oral input today. PEG feeds stopped 6/2/99. Calm in himself but frightened. No new blisters. (page 94)
Contact record – **diamorphine dose range increased**. Driver renewed. Diamorphine increased to 250mgs. Sips of fluid taken. Whimpering in sleep. (page 147)
Clinical notes – **increase diamorphine to 250mgs S/C via syringe driver**. (upto 300 mgs). If still distressed and frightened change midazolam to haloperidol via syringe driver. Stop all oral medication and insulin. Stop checking sugars. No further PEG feeds. Wife aware he is dying. If he dies could **nursing staff please confirm**. (page 95)
11th February 1999
Clinical notes – agitated very restless last night. Dry, pyrexial and chesty. Bronchopneumonia.
Contact record – **driver charged diamorphine 300mgs**. (page 148)
14th February 1999
Contact record – **in pain on movement**. Awake and anxious. **Diamorphine 400mgs via syringe driver.** (page 148)
15th February 1999
Clinical notes – Haloperidol not effective back on midazolam asleep. No apparent distress. Marked general deterioration. Continue syringe driver. (page 96)
Contact record – seen by Dr Barton boarded for review of syringe driver. No change in treatment to be kept comfortable. Condition deteriorated. Family notified. (page 148)
16th February 1999
Clinical notes – 06.10 hours died. Confirmed by C Marjoram. (page 96) Staff Nurse.

Comment

Mr Code A was only 69 years old. He had a dense left sided paralysis. He was unable to eat normally and had a PEG feed inserted in March 1997. He was transferred to Gosport War Memorial Hospital for continuing care. He was to be discharged to a nursing home, unfortunately he became MRSA positive and few nursing homes were prepared to accept him. He was on the verge of discharge on several occasions. Nursing care plans did contain evidence that he was a very ill man with extensive nursing and care needs. Mr Code A deteriorated, the nurses seemed unable to clear his MRSA. He developed blisters and this caused his skin to break down. He itched and was uncomfortable. He was in pain and by October 1998 he had been started on Diamorphine and a Syringe driver. By January 1999 it was noted that Mr Code A's prognosis was poor, he was in severe pain and distress. His skin was breaking down. In February 1999 his Diamorphine was increased from 100 mgms to 400 mgms by 14th February. His family were notified and Mr Code A died on 16th February at 06.10 hours. Although he was a very ill man there is evidence that Mr Code A sometimes was allowed to deteriorate when a proactive approach by the nurses could have maintained his skin integrity and allayed some of his fears. There was no evidence of with holding medication or food.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A		2A		
Unclear B				
Unexplained by Illness				

6.65. Code A

Code A Age: **85**

Date of Admission to GWMH: **10th February 1999**
Date and time of Death: **15.10 hours on 22nd March 1999**
Cause of Death:
Post Mortem: Burial
Length of Stay: **42 days**

Code A s past medical history:-

- Code A

Mrs Burt lived with her son in a second floor flat. In the summer of 1997 Mrs Burt's son was admitted to hospital with Code A and was not expected to come out. Her daughters from Norway and Canada came home and helped to look after Mrs Burt for a while but were due to go home, so help was needed to care for Mrs Burt. Mrs Burt's grandson visited once a week to help with shopping and housework. On 16th January 1999 Mrs Burt sustained a fall at home and fractured her right neck of femur. She underwent a hemiarthroplasty on 19th January 1999 at Haslar Hospital and was transferred to the Gosport War Memorial Hospital on 10th February 1999 because she was failing to progress. (page 14/15/16)
On admission it was noted that Mrs Burt needed 2 nurses to transfer but could walk with the aid of a zimmer frame. A Barthel score of 2 was noted. Also noted was that Mrs Burt was content and bright. She was fussy, particularly about food and drink. (page 16/17)
Care plans were completed on admission for hygiene, constipation, and sleep. A mouth evaluation was completed as well as a nutritional assessment and a handling assessment. Regular Waterlow scores and barthel scores were also recorded.

Daily summary
9th February 1999
Clinical notes – not suitable for rehabilitation. Case conference view Nursing home and Dr Banks' opinion. (page 48)
10th February 1999
Clinical notes – transfer to Dryad Ward. (page 50)
Summary – admitted from St Mary's General Hospital following right hemiathroplasy at Haslar on 19th January 1999. Lived at home – had a fall ? secondary to MI. Since being at St Mary's has failed to mobilise. She can mobilise using a zimmer and 1 nurse but this is variable. Has poor diet and fluid

intake to have psychogeriatrician referral. Cold on arrival. Complaining of headache. (page 108)

11th February 1999
Clinical notes – seen on Dryad ward. Content and bright. Does not wish to die. Is fussy and particular about food and drink. (page 17)
Clinical notes – seen by Dr Banks visit tomorrow in the meantime push fluids. (page 51)
Summary – while being washed had an episode of being unresponsive. (page 108)
15th February 1999
Clinical notes – needs encouragement eating. For social worker referral. ? RH (residential home) or ? NH (nursing home). (page 51)
25th February 1999
Clinical notes – very alert. Concerns alcohol taken. Still very reluctant to eat and drink. Transfers with 1 person. (page 52)
1st March 1999
Clinical notes – unchanged. Still reluctant to eat and drink. Needs nursing home care refer to social worker. (page 52)
Summary – seen by Dr Reid no change. (page 108)
3rd March 1999
Summary – social worked visited. (page 109)
8th March 1999
Clinical notes – still very reluctant to eat and drink. Mobilises when she wants to. Barthel 10. Social worker reluctant to place re: eating problems. (page 52)
Summary – to stay until 26/3/99 when daughter will return to look for Rest Home placement. (page 109)
14th March 1999
Summary – condition deteriorated. (page 109)
15th March 1999
Clinical notes – sips of water only refuses food and drugs. Comfortable. Skin intact. Barthel 5 for TLC. (tender loving care) (page 52)
16th March 1999
Clinical notes – social services – NH not appropriate. (page 53)
Summary – **complaining of severe pain**. **Oramorph 5mgs** given with effect. (page 109)
17th March 1999
Summary – daughters arrived. (page 109)
18th March 1999
Summary – **complaining of severe generalised pain**. Refusing oral oramorph. **Syringe driver commenced with 20mgs diamorphine**. Discussed with daughter. (page 110)

19th March 1999
Summary – **syringe driver renewed 20mgs diamorphine**. Daughters staying overnight. (page 110)
20th March 1999
Summary – remains comfortable. Condition continues to deteriorate. Diamorphine 20mgs via syringe driver. For burial. (page 110)
21st March 1999
Summary – no change. **Syringe driver charged 30mgs diamorphine** increased due to some discomfort and stiffness when being attended to. (page 110)
Suction required as bringing up bile stained fluid. (page 111)
22nd March 1999
Clinical notes – died 15.10 hours. Verified by S Hallmann. Doctors notified. For burial. (page 53)
Summary – syringe driver recharged 30mgs diamorphine. Died 15.30 hours doctors surgery informed. (page 111)

Comment
Code A had fallen at home and fractured her right neck of femur. She had surgery to repair this but appeared to be unable or unwilling to mobilize after surgery. Nursing care plans were made and the care when recorded appeared to be consistent with the plan and appropriate to Code A s care needs. She had a high Waterlow score but little evidence of turning or special mattress provided. There is no evidence of neglect.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A		2A		
Unclear B				
Unexplained by Illness				

6.66. BJC63 Frank Horn

Code A Age: **90**

Date of Admission to GWMH: **5th November 1999**
Date and time of Death: **04.30 hours on 12th November 1999**
Cause of Death:
Post Mortem: Cremation
Length of Stay: **7 days**

Mr Horn's past medical history:-

Code A

Mr Horn lived with his daughter. He wore a hearing aid. On 12th October 1999 Mr Horn was admitted to the Queen Alexander Hospital with shortness of breath and chest pains. He was discharged on 21st October 1999 only to be readmitted on 23rd October 1999 with a chest infection, heart failure and swallowing difficulties. He was catheterised. On 5th November 1999 Mr Horn was transferred to the Gosport War Memorial Hospital and it was hoped after rehabilitation he would be transferred to a Residential home. (page 9/10)
On admission care plans were commenced for hygiene, catheter, constipation due to mobility and sleeping. A Barthel score of 3 was recorded as well as a Waterlow score of 19. It was also noted that Mr Horn could transfer with the aid of a nurse.

Daily summary
5th November 1999
Clinical notes – transfer for continuing care to Dryad Ward. Barthel 4. Transfers with 1. Short of breath. Not for resus. **Happy for nursing staff to confirm death**. (page 90)
Summary – admitted to Dryad ward for period of assessment and rehabilitation. On arrival seemed a little short of breath. Swallowing problems. (page 166)
9th November 1999
Clinical notes – seen by SALT recommended soft moist diet. (page 90)
10th November 1999
Clinical notes – marked deterioration over last 24 hours **S/C analgesia** is now appropriate. (page 91)
Contact record – contacted daughter re: deterioration. Explained need for syringe driver. (page 170)
Summary – **commenced on syringe driver. Diamorphine 20mgs**. Further deterioration. Some food and fluid taken. (page 166)
11th November 1999

Clinical notes – further deterioration. Comfortable on **S/C analgesia**. Happy for nursing staff to confirm death. (page 91)
Summary – **comfortable very twitchy, distressed**. Syringe driver recharged with **40mgs diamorphine**. Remains very chesty appears pain free. (page 166)
12th November 1999
Clinical notes – died at 04.30 hours. Verified by RGN I M Dorrington. (page 91)
Summary – continued to deteriorate. Died at 04.30 hours for cremation. Family present. (page 167)

Comment
Mr Horn was a frail elderly man of 90 who had a complex medical history. It was hoped that he would respond to rehabilitation at Gosport War Memorial Hospital and he would be discharged to a residential home.
A syringe driver was set up 5 days after admission with Diamorphine 20 mgs, Midazelam 20 mg and Hyoscine 40 mcg. even though there is no record that he was in pain. The nurses do not appear to have challenged this decision. He became twitchy on 11th November, there is no evidence that the nurses questioned if he might be opiod toxic as he had not complained of pain.
Nurses are required to understand the effects of the medication they administer and be aware of signs of side effects of the medication. The nurses failed to display an acceptable knowledge of Mr Horn's medication. This was below an acceptable standard for competent nurses at this time.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B		2B		
Unexplained by Illness				

6.67. Code A

Code A Age: **86**

Date of Admission to GWMH: **31st March 1999**
Date and time of Death: **00.45 hours on 8th April 1999**
Cause of Death:
Post Mortem: Burial
Length of Stay: **9 days**

Mrs Miller's past medical history:-

Code A

Code A was looked after at home by her daughter, she had previously been in a Nursing Home. In March 1999 Code A was admitted to Queen Alexander Hospital with Code A The nursing report noted that there was a fair amount of neglect. It was also noted that Code A was Code A managed a good diet and needed 2 nurses to transfer but could manage a few steps with a zimmer frame. Code A was transferred to Gosport War Memorial Hospital on 31st March 1999 where it was noted that she had a poor mental state and that they did not feel rehabilitation would be successful and she was to have a bed on Daedalus ward for a 4-6 week period of assessment. (page 7/8/11/12)
On admission care plans were commenced for hygiene, catheter, pressure sore left buttock, nutrition and to settle at night.
A handling profile was completed noting that Code A had limited understanding and had difficulty hearing. It notes that she says she was in pain and that her skin was dry and at risk of developing pressures sore. Code A was nursed on a Pegasus mattress.
A nutritional assessment form was completed as well as a Waterlow score of 21 recorded.

Daily summary
31st March 1999
Transfer form – from Haslar to Daedalus ward. Code A
Code A with a view to **setting up full home care package of Nursing Home placement**. (page 13/14)
Clinical notes – transfer to Daedalus ward for continuing care. Small sacral pressure sore. May need catheter. Barthel 3. Plan to get to know, make comfortable. **Happy for nursing staff to confirm death**. (page 16)

4th April 1999
Contact record – since admission eating and drinking minimal amounts and refusing medication. Cold and uncomfortable on moving. Daughter contacted and informed aware outlook not good and agrees to force-feeding. **Use of syringe driver explained**. 18.00 hours pain on movement[2]. Vomited and distressed. **S/C analgesia commenced.** 19.35 hours deteriorating. (page 29)
5th April 1999
Contact record – daughter informed of deterioration. Visited and said her goodbyes. (page 29)
6th April 1999
Clinical notes – deterioration over weekend. **On S/C analgesia more comfortable. 20mgs Diamorphine**. For Burial. (page 16)
8th April 1999
Clinical notes – 00.45 hours found dead in bed. Confirmed at 00.50. Relatives informed. (page 16)
Contact record – 00.45 found dead in bed. Daughter informed but did not want to visit.

Comment
This lady was very unwell and it was clear that she could no longer care for herself at home. She was admitted form a nursing home to Queen Alexandra Hospital, where she was found on admission to be suffering from diarrhoea and vomiting. The clinical notes at Gosport state that the doctor is happy for the nurses to confirm death but the nurses talk about discharge with a package of care. It was unclear why analgesia was necessary and I saw no evidence that the nurses had questioned the decision.
The care did appear to be an acceptable standard.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A		2A		
Unclear B				
Unexplained by Illness				

[2] There was no other evidence for this statement.

6.68. Code A

Code A Age: **94**

Date of Admission to GWMH: **7th May 1998**
Date and time of Death: **12.35 hours on 10th May 1998**
Cause of Death:
Post Mortem:
Length of Stay: **4 days**

Code A 's past medical history:-

- Hysterectomy 1961
- Fracture right femur 1983
- Fracture right humeral head 1985
- Cataract extraction 1988
- Pernicious anaemia 1993
- Fracture right femur 1994
- Thyroidectomy
- Chronic renal failure
- Osteoporosis
- Osteoarthrosis
- Confusion
- Cholelithiasis

Code A She had a son who was a local GP. Code A was admitted to the Hospital after a fall on 28th April 1998. She sustained a laceration to her right elbow and bruising to her right shoulder and hip. Code A was noted to have severe postural hypotension, had poor mobility, she was Code A and was deaf and did not like using her hearing aid. She was also noted to have **chronic renal failure**. On 7th May 1998 Code A was transferred to the Gosport War Memorial Hospital for a 4-6 week assessment on Dryad Ward. (page 10)
On admission care plans were commenced for hygiene, constipation, abrasion right elbow and to settle at night.
A nutritional assessment form was completed as well as a Waterlow score of 23 recorded. A barthel score of 5 was also recorded.

Daily summary
7th May 1998
Summary – admitted from Russell Church Court. Fall on 28th April 1998 sustaining bruising to right shoulder. Mobility and confidence very poor. Skin very dry heels spongy. Constipated. **Observe for pain**. Very deaf. For mobilising if postural hypotension improves. Code A (page 79)

8th May 1998
Summary – commenced on **oramorph 5mgs/4 hourly for pain relief**. Right elbow dressed. Bowels opened. (page 79)
Clinical notes – admitted for continuing care to Dryad Ward. Help with eating. Barthel 4. (page 97)
9th May 1998
Summary – **very sleepy** this pm. Very little diet and fluids taken. **Oramorph 5mgs/4 hourly given and 10mgms at night.** Very bubbly when breathing. 23.30 condition appears to gradually deteriorating. Not swallowing. **Syringe driver set up with diamorphine 40mgs**. Tried to contact family. (page 79)
10th May 1998
Summary – continues to deteriorate appears comfortable. 12.35 hours died. Daughter in law present. (page 80)
Clinical notes – 12.25 hours not responsive. Death verified S Hallmann and M Theadas. (page 97)

Comment
Code A was frail with a long medical history and with chronic renal failure. On admission it was noted that she was to be observed for pain, there was no note to say that she had pain. The following day she was started on Oramorph 5 mgms 4 hourly for pain relief.
The following day she was being given Oramorph, it was noted that she was sleepy and had bubbly breathing.. At 23.30 it was noted that she was deteriorating. A syringe driver was set up with 40 mgms of Diamorphine.
There was no evidence that Mrs Code A was in pain. She had chronic renal failure and was given 30 mgms Oramorph a day. The nurses failed to query this and did not record that Mrs Code A was in pain.
This is a standard of care below that expected of competent nurses at this time.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B		2B		
Unexplained by Illness				

6.69. BJC66 Phyllis Horne

Code A Age: **82**

Date of Admission to GWMH: **26th March 1998**
Date and time of Death: **09.40 hours on 6th May 1998**
Cause of Death:
Post Mortem:
Length of Stay: **42 days**

Mrs Horne's past medical history:-

- Alzheimer's
- Cholecystectomy
- Fracture tibia

Mrs Horne was a widow. She was one of 7 children, her parent died when she was young and she was bought up by her eldest sister. Mrs Horne's husband died in September 1995. He was a driving instructor who ran his own business. When he died the business was passed onto his son. Mrs Horne had three grandchildren. Mrs Horne lived in a flat but due to the deterioration in her health, she moved to Acorn Lodge Residential Home. Mrs Horne was admitted to Queen Alexandra Hospital on 16th March 1998 suffering with dizzy spells. Two weeks previously she had suffered a minor CVA with facial palsy. She was transferred to Gosport War Memorial Hospital on 26th March 1998 for continuing care.
On admission care plans were commenced for hygiene, constipation, catheter, eating and drinking and to settle at night.
A Waterlow score of 22 recorded and a Barthel score of 0 was also recorded. A handling profile and evaluation was also completed.

Daily summary
26th March 1998
Clinical notes – transferred to Dryad ward for continuing care. Needs hoist for transfers, has been catheterised and needs helps with all activities of daily living. Barthel 0. Plan – get to know and for TLC. (page 33)
Summary – Transferred this morning from Mulberry after being admitted to Queen Alexandra Hospital on 16th March 1998. CT scan on 20th March 1998 shows brain atrophy. (page 41)
27th March 1998
Clinical notes – not eating or drinking. Happy for nursing staff to confirm death. (page 33)
30th March 1998
Clinical notes – needs to be fed. Slow swallow. Catheterised some problems with by passing. NHS continuing care for 1 month then decide on placement ? Nursing Home. Would like to go back to Acorn Lodge. (page 33/34)
Summary – seen by Dr Lord. Will review end of April. (page 42)

6th April 1998
Summary – distress and agitated. Catheter not draining. Catheter removed. (page 42)
12th April 1998
Summary – distressed and agitated. (page 42)
27th April 1998
Clinical notes – confused some sign of rig? as well as some agitation. Dr Banks to review. (page 34)
Discussion with Dr Banks agrees prognosis is poor. Give up place at Residential Home. To stay for another two months. Review decision on placement. (pge 35)
Summary – seen by Dr Lord. To be seen by Dr Banks on Friday for further 2-month assessment. (page 42)
1st May 1998
Summary – family concerned 'getting worse'. (page 42)
3rd May 1998
Clinical notes – frightened, agitated, appears in pain. Suggest Tramadol analgesia despite no obvious clinical justification! Dr Lord to countersign. Happy for nursing staff to confirm death. (page 36)
Summary – **fentanyl patches commenced 25mcgms** afternoon. (page 43)
5th May 1998
Clinical notes – further deterioration in overall condition. Won't swallow medication. Now for **S/C analgesia**. Make comfortable.
Reviewed by Dr Banks. Appears peaceful. (page 36)
Summary – seen by Dr Barton deterioration. 09.40 hours driver commenced with **40mgs diamorphine**. (page 43)
6th May 1998
Summary – 9.40 hours unresponsive. Examined by S/N P. Shaw and S/N F. Shaw verified dead at 09.45 hours. Dr Barton notified. (page 43)

Comment
This lady was not showing any sign of pain, they noted that she was distressed and agitated. This does not always imply pain. A 25mcgm Fentanyl patch was commenced on the afternoon of 5th May, the next day a syringe driver was set up with 40 mgms of Diamorphine at 9.40 in the morning. There is no evidence that the nurses queried this and a competent nurse at this time should have asked about using a Fentanyl patch and then setting up a syringe driver. This is below an acceptable standard.

Operation Rochester. **Clinical Team's Assessment Form**				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B		2B		
Unexplained by Illness				

6.70. BJC67 Ruby Lake

Code A Age: **84**

Date of Admission to GWMH: **18th August 1998**
Date and time of Death: **18.25 hours on 21st August 1998**
Cause of Death:
Post Mortem:
Length of Stay: **4 days**

Mrs Lake's past medical history:-

- Gout right wrist
- LVF
- MI
- Aortic sclerosis
- Chronic renal failure
- AF
- Varicose veins
- Hypertension
- Osteoarthritis
- Leg ulcers

Mrs Lake was a widow. She lived on her own and was supported by her 3 daughters. She wore a hearing aid and the district nursed attended weekly to dress bilateral leg ulcers. On 5th August 1998 Mrs Lake was admitted to the Royal Haslar Hospital via accident and emergency after falling at home. She fractured her left neck of femur and underwent a left cemented hemiarthroplasty later that day. Mrs Lake recovery was slow as she suffered from bouts of angina and breathlessness. She was transferred to Gosport War Memorial Hospital on 18th August 1998 for continuing care. The transfer letter noted that Mrs Lake could slowly mobilise with the aid of a Zimmer frame and had a broken area of skin on her left buttock and on the cleft of her buttocks. It also noted that she had a small appetite and needed lots of encouragement.

Daily summary
18th August 1998
Clinical notes – transferred to Dryad ward for continuing care. Fracture neck of femur (left) on 5/8/98. Catheterised, transfers with 2 nurses. Barthel 6. Plan – Get to know, gentle rehabilitation. Happy for nursing staff to confirm death. (page 72)
21st August 1998
Clinical notes – died peacefully 18.25 hours. Verified by S/N Ring and S/N Theadorus. (page 72)

Comment

There were no drug charts included in the Bundle. It was not clear what nursing care was given. If the lack of records is an indication that no assessment for care needs was made, no care plan drawn up and no risk assessments made, then this was a standard of care which was far below an acceptable standard expected of competent nurses at the time. The lack of an appropriate care plan and evaluation sheet means that with no information about the care assessed or given that the poor outcome of this nursing episode would indicate a poor standard of care.

Operation Rochester. **Clinical Team's Assessment Form**				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B				
Unexplained by Illness				

6.71. BJC68 Mabel Leek

Code A Age: **92**
Date of Admission to GWMH: **6th August 1998**
Date and time of Death: **17.15 hours on 18th December 1998**
Cause of Death:
Post Mortem: Cremation
Length of Stay: **135 days**

Mrs Leek's past medical history:-

- Fracture left hip 1995
- Hysterectomy
- Bilateral cataract extraction 1985
- Angina 1989
- Appendectomy
- Tonsillectomy
- Osteoarthritis knees 1983
- Osteoporosis

Mrs Leek had two daughters who lived in Gosport. She lived on her own with extended home care visiting twice daily. She also had meals on wheels and a home help. Mrs Leek was allergic to aspirin. Mrs Leek fractured her left tibia and fibia, which was plated at Royal Haslar Hospital. Mrs Leek was transferred to Gosport War Memorial Hospital on 6th August 1998 for further rehabilitation.

On admission care plan commenced for sleeping, catheter, small necrotic ulcer right heel, hygiene, POP on left leg, wound on left leg, MRSA (barrier nursed), pain in knees and red sacrum. A Waterlow score and Barthel score were recorded fortnightly and a handling profile was completed noting Mrs Leek had pain in both knees, was nursed on Pegasus mattress, skin intact and needed the assistance of 2 nurses, a hoist and glide sheet.

Daily summary
6th August 1998
Transfer letter – from Haslar to Dryad Ward. Transfers with a zimmer and 2 nurses. Needs assistance with hygiene. Needs lots of encouragement and physio. Leg needs to be elevated with four pillows on top of a chair to reduce swelling. (page 21)
Clinical notes – admitted to Dryad ward with **fracture to left tibia and fibia**. (page 90)
Summary – admitted from Haslar following fracture left tibia reduction fixed with plate and screws. POP in situ. Large lacerations under plaster. Photos in notes.
Code A difficulties with mobility. (page 341)

7th August 1998
Summary – **oramorph given 10mgs**. (page 341)
8th August 1998
Summary – **breakthrough pain boarded for MST 40mgms bd**. (page 341)
10th August 1998
Clinical notes – seen by SLT review 2 weeks. (page 90)
24th August 1998
Clinical notes – seen by SLT. (page 91)
1st September 1998
Clinical notes – swallowing problems. Restless at night. (page 91)
Summary – seen by Dr Barton. (page 342)
14th September 1998
Clinical notes – not mobile. Barthel 6. Ulcer left ankle much same. **Pain left heel. Catheterised. Oramorph for pain then on MST 50mgs increasing to 60mgs** (on long term MST). (page 92)
Summary – seen by Dr Lord. (page 342)
4th October 1998
Summary – very difficult to manage. (page 342)
13th October 1998
Summary – arrangements made to transfer to Royal Haslar Hospital for review of POP causing distress, more swollen over last few das. Bed elevated. (page 343)
Clinical notes – complaining of swelling foot. (page 94)
Clinical notes – referral to Royal Haslar Hospital cast seems tight, foot swollen. (page 10/11)
Clinical notes – accident and emergency department. ORIF left ankle 8 weeks ago and scotch cast now increasing pain under scotch cast. Cast removed today much improvement. On examination **clear dry ulcer 3cm x 3cm**. Surgical scar healed x-ray fracture site united acceptable postal ?? backing out of screws. Plan – walking boot and gentle mobilising. (page 8)
19th October 1998
Clinical notes – **pressure sore on heel**. Plastic surgeon to review. (page 9)
Summary – has been to Haslar for review. **Small necrotic area on left heel**. (page 343) Spilt milk on arms and fore arm. Slight redness. Accident form completed. (page 344)
26th October 1998
Clinical notes – went to Royal Haslar Hospital. Cast removed for **MST 70mgs**. Right knee painful, **heel black area**. Barthel 5. Residential care discussed. (page 94
Summary – seen by Dr Lord once ulcer healed for rehab with physio. (page 344)
28th October 1998
Summary – seen by Dr Barton re pain control **MST increased from 70 to 80** mgms. (page 344)
9th November 1998

Clinical notes – Barthel 4. Left heel ulcer sloughly surrounding skin inflamed. Pain reasonable, controlled. (page 95)
Summary – seen by Dr Lord to commence Flucloxacillin 500mgs for 7 days because of swelling near the ulcer on left ankle. (page 344)

20th November 1998

Summary – heel swab taken. (page 344)

23rd November 1998

Clinical notes – **on increase dose of MST**. Left heel clean smaller but little slough. Healthy tissue around. To nursing home in New Year if stable. Mrs Leek agrees. (page 95)
Summary – Nursing home subject bought up with patient and daughters. Dr Lord pleased with progress of heel ulcer. (page 344)

1st December 1998

Summary – heel swab retaken. (page 344)

3rd December 1998

Summary – not ready for discharge. Refer to Haslar Social Services. (page 344)

7th December 1998

Clinical notes – heel ulcer sloughly with some necrotic tissue. Pain better less drowsy. (page 96)
Summary – seen by Dr Lord no change in treatment. To be reviewed in New Year. (page 345)

13th December 1998

Summary – **unresponsive at times**. No supper taken but did have a drink. (page 345)

14th December 1998

Clinical notes – deteriorated over weekend. **Pain relief a problem start S/C analgesia and make more comfortable**. Happy for **nursing staff to confirm death. (page 96)**
Summary – **remained unresponsive when moved in pain**. Seen by Dr Barton. **Syringe driver commenced** with **diamorphine 80mgs.**

15th December 1998

Clinical notes – **further deterioration on S/C analgesia and comfortable**. (page 97)
Summary – syringe driver recharged with **diamorphine 80mgs still appears in pain and distressed at being moved. Syringe driver recharged with diamorphine 100mgs. (page 345)**

16th December 1998

Summary – **syringe driver recharged with diamorphine 100mgs**. Still distressed. (page 345)

17th December 1998

Summary – syringe driver recharged with **diamorphine 130mgs.** (page 346)

18th December 1998

Clinical notes – died 17.15 hours verified by S/N Shaw and S/N Wigfall. (page 97).

Summary – **syringe driver recharged with diamorphine 160mgs**. Condition deteriorated. Died at 17.15 hours for cremation. (page 346)

Comment

Mrs Leek was admitted to Gosport from the Royal Haslar Hospital after she had surgery to plate her left tibia and fibia and she was to have rehabilitation. She was nursed on a Pegasus mattress to try and prevent further pressure damage. She was prescribed morphine (MST 40 mgms) on 8th August 1998 for breakthrough pain.. On 14th September 1998 she was prescribed Oramorph and then MST 50 mgms to increase to 60 mgms MST. She developed pressure damage from the plaster cast on her leg. The pressure damage on her heel deteriorated and became infected. On14th December 1998 Mrs Leek was started on a syringe driver for pain relief. The clinical notes state that the doctor is happy for the nurses to confirm death. The dose of diamorphine and Midazolam in the syringe driver increased rapidly from:-

- 80 mgms with Midazolam 10 mgms. on 14th December 1998
- 80 mgms and Midazolam 30 mgms at 0300 on 15th December 1998
- 100 mgms was put up with Midazolam 50mgms later the same day.
- 100mgms Diamorphine on 16th December 1998
- 130 mgms Diamorphine, Midazolam 70 mgms and Hyoscine 400 mcgms on 17th December 1998.
- 160 mgms Diamorphine, Midazolam 80 mgms, Hyoscine 1200 mcgms.

The reasons for this rapid escalation of medication was not explained. It is suggested that the nurses accepted verbal changes (increases) from the doctor to the medication above by telephone in the middle of the night.
This is very poor practice and is not allowed under any circumstances by the then UKCC, the regulating body for nurses. The Nurses have clear guidelines that verbal orders are not acceptable. The nurses also administered this rapidly increasing cocktail of medication without any evidence that they queried its use. This is below an acceptable standard of care for nurses at this time.

Operation Rochester. **Clinical Team's Assessment Form**				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B		2B		
Unexplained by Illness				

6.72. BJC69 Euphenia Skeens

Code A Age: **87**

Date of Admission to GWMH: **20th October 1995**
Date and time of Death: **22.40 hours on 29th October 1995**
Cause of Death:
Post Mortem: Cremation
Length of Stay: **9 days**

Mrs Skeens had no major past medical history to report.

Mrs Skeens was a widow. She had a son. Mrs Skeens lived on her own in a bungalow and had the help of a carer. She was a heavy smoker and reacted badly to antibiotics. She had been falling a lot at home prior to her admission to hospital. Mrs Skeens was admitted to Queen Alexandra Hospital on 10th October 1995 after suffering a right CVA with left hemiparesis. On 20th October 1995 Mrs Skeens was transferred to the Gosport War Memorial Hospital for long stay rehabilitation.

Care plans commenced on admission for catheter, constipation, movement and mobility, hygiene and to settle at night. A Barthel score was recorded on 20th October and 22nd October scoring 5 and 3. A nutritional assessment was also completed noting a score of 7.

Daily summary
20th October 1995
Transfer form – noting Mrs Skeens was on a soft diet and needed assistance with feeding. She needed assistance with all activities of daily living. At present hoisted in and out of bed. Incontinent and prone to constipation. Left leg very weak and left arm becoming still. Appears slightly chesty. (page 7)
Clinical notes – transferred from Queen Alexandra Hospital **for long stay rehabilitation**. Plan – to get to know. (page 19)
Summary – admitted to Daedalus Ward for slow stream stroke care. Right CVA with left hemiparesis 1/10/95 had a fall at home and was admitted to QAH on 10/10/95 has become less able was previously self-caring. Swallowing problem. Urine very offensive. (page 50)
21st October 1995
Summary – catheterised. (page 50)
23rd October 1995
Clinical notes – unable to transfer needs hoist. Now catheterised. Barthel 3. Mental state strange. (page 20)
Summary – seen by Dr Lord continue physio. (page 50)

24th October 1995
Clinical notes – seen by SALT sounding chesty has delayed swallow. To have puree diet/thickened cold fluids only in small amounts under close supervision. (page 20)
Summary – seen by SALT, trial with cold fluids, thin fluids. (page 50)
25th October 1995
Clinical notes – need to see son and NOK re further management with antibiotics – quite chesty. (page 21)
Summary – seen by Dr Barton would like to speak with son. (page 51)
26th October 1995
Clinical notes – condition deteriorating difficulty swallowing. **? need opiates ? no antibiotics. Happy for nursing staff to confirm death**. Family understand mothers condition and happy with management. (page 21)
Summary – very restless and distressed. **Complaining of pain in left arm. Oramorph 5mgs given** with good effect. (page 51)
27th October 1995
Summary – **oramorph increased to 10mgs with good effect as in pain and restless**. Taking thickened fluids well. (page 51)
28th October 1995
Summary – distressed and restless. **Syringe driver commenced 40mgs diamorphine**. Son informed. **Became very peaceful and relaxed**. Breathing deteriorated at 11.15 son informed. (page 49)
Summary – became quite agitated and restless unable to communicate. Appeared chestier very little urine passed. Catheter block, washout performed. Oramorph 10mgs given. (page 51)
29th October 1995
Clinical notes – died 22.40 hours death confirmed by CJ Marsden. For cremation. (page 21)
Summary – turned 3 hourly all care given. Syringe driver renewed. Continued to deteriorate. Died 22.40 hours.
30th October 1995
Summary – son informed at 07.45 hours will visit tomorrow. (page 49)

Comment
Mrs Skeens was admitted to Gosport War Memorial Hospital on 20th October 1995 for the slow stream stroke rehabilitation. She was chesty and had difficulty swallowing. She was seen by SALT for this. On 26th October noted that Mrs Skeeens was deteriorating and possibly needed opiates, and may not be treated with antibiotics. Dr Barton was again "happy for the nurses to confirm death". She was given Oramorph 5 mgms on 26th October with good effect. This was increased to 10 mgms the folloing day. A syringe driver was set up on 28th October with 40 mgms of Diamorphine and 20 mgms of Midazolam. This effectively doubled the analgesia. Mrs Skeens became peaceful and relaxed. She

then became restless and distressed and unable to communicate. Oramorph 10 mgms was given. Mrs Skeens died the following day.
The nurses in my opinion failed to challenge the doctor on the dosage of medication prescribed which they administered. This omission was not in the interests of the patient Mrs Skeens and the standard of nursing care in this case was below an acceptable level.
She died of bronchopneumonia and was in pain.

Operation Rochester. **Clinical Team's Assessment Form**				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A		2A		
Unclear B				
Unexplained by Illness				

6.73. BJC70 Rhoda Marshall

Code A Age: **84**

Date of Admission to GWMH: **29th December 1995**
Date and time of Death: **14.30 hours on 7th January 1996**
Cause of Death:
Post Mortem:
Length of Stay: **10 days**

Ms Marshall's past medical history:-

- Multi infaract dementia
- Parkinson's disease
- Hypothyroidism
- Heart failure

Ms Marshall lived in a Residential Home. Her nephew was noted as her next of kin. Ms Marshall was admitted to Queen Alexandra Hospital on 14th December 1995 after fracturing her pubic rami. Ms Marshall was transferred to Gosport War Memorial Hospital for long-term rehabilitation.

On admission care plan commenced for blister left heel, catheterised, hygiene, pain and to settle at night. A further care plan commenced on 2nd January 1996 for sacral area breaking down. A barthel score of 0 was recorded on 30th December 1995 and a waterlow score of 28 was recorded on 2nd January 1996.

Daily summary
28th December 1995
Transfer form – from QAH to GWMH Ms Marshall is on a normal diet needs assistance with feeding and drinking. Skin intact but has dressing left heel. Needs assistance with washing and dressing and feeding. Catheterised. Transfers with a hoist. (page 138)
29th December 1995
Clinical notes – transferred from Anne Ward for long-term rehabilitation. **Needs increase pain relief**. Recently stopped antibiotics due to diarrhoea. (page 76)
Summary – admitted with fracture pubic rami, blisters on left heel with granuflex dressing. Seen by Dr Briggs to continue. Vaginal discharge noted. To assess re: mobilisation. ? Long-term care. Not weight bearing. Catheter in situ. Encourage fluids. (page 12)
30th December 1995
Clinical notes – pain control inadequate. For **oramorph 10mgs**. (page 77)
Summary – appears to be in pain at slightest movement. Seen by Dr Knapman charted for oramorph 10mgs 4 hourly. Still appears in pain. (page 12)

2nd January 1996
Clinical notes – not so well in herself. Not feeding well now. Needs S/C analgesia. (page 77)
Summary – seen by Dr Barton **commenced on syringe driver with diamorphine 40mgs to give continuous pain relief**. Pressure mattress changed from spenco to pegasus as **sacrum broken and discoloured**. Driver continues more settled and calm. (page 12)
3rd January 1996
Summary – seen by Dr Barton still to be in discomfort ? anxiety ? pain. Swabbed for MRSA. Son seen and aware of poor condition. **Pain appears uncontrolled.** Nursed 2 hours on back 4 hours on left side as too painful to lie on right side. Still appears in pain when moved. Very anxious. (page 13)
4th January 1996
Summary – further deterioration. Seen by Dr Barton syringe driver renewed with **diamorphine 80mgs**. Seen by Dr Barton again remains agitated. Syringe driver renewed with **diamorphine 120mgs**. Observer further signs of distress. Continues to deteriorate. Nurses on back and left side. (page 14)
5th January 1996
Summary – driver **recharged 120mgs diamorphine**. (page 14)
6th January 1996
Summary – continues to deteriorate slowly. Driver recharged with **120mgs diamorphine** appears comfortable. (page 14)
7th January 1996
Summary – condition continues to deteriorate turned 2 hourly. Sacral area deteriorating red, broken and sore. Nursed on alternate sides. Driver still in situ. (page 14)
14.30 hours died. Dr Beasley informed. Nephew informed. (page 16)

Comment
Mrs Marshall was transferred to GWMH from Queen Alexandra Hospital for long-term rehabilitation. She was unable to weight bear, had discontinued antibiotics because she had diarrhoea and her skin had started to break down. Mrs Marshall had a Waterlow score of 28 yet the nurses only used a Spenco mattress until she developed pressure damage when thy put Mrs Marshall on a Pegasus bed. Had this been used on admission pressure damage might have been less or prevented. The nurses showed a poor level of knowledge about the prevention of pressure damage and this was below an acceptable standard expected of competent nurses at the time.
There was a very poor prescription for a controlled drug on p116 and the nurses should not have administered the medication until it was corrected. There was some doubt as to the level of medication in this case.

Operation Rochester. **Clinical Team's Assessment Form**				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B		2B		
Unexplained by Illness				

6.74. Code A

Code A Age: **83**

Date of Admission to GWMH: **13th December 1995**
Date and time of Death: **01.45 hours on 24th January 1996**
Cause of Death:
Post Mortem: Cremation
Length of Stay: **43 days**

Code A past medical history:-

- Parkinson's disease

Code A

- Hypothyroidism

Code A grew up in Hemel Hempstead. He joined the navy when he was 14 years old and moved to Portsmouth. He was married and had a son and 2 daughters, 1 died. Code A could no longer cope with Code A deteriorating mobility so in January 1993 Mr Pittock moved to a Residential Home. Mr Pittock was admitted to Gosport War Memorial Hospital on 13th December 1995 as the Residential Home could no longer cope with him.

A care plan commenced on admission for Code A and on 6th January 1996 for hygiene, Code A sacral area sores, catheter and sleeping. Another care plan commenced on 11th January 1996 for dietary and fluid intake. Waterlows score were recorded on 6th January 1996 with a score of 24 and on 22nd January 1996 with a score of 36. A nutritional assessment plan commenced on 7th January 1996 with a score of 6 recorded. Pressure sore documentation commenced on 16th January 1996 for sores on sacrum, left hip, left foot x 2 and right ear. A mouth assessment on 18th January 1996 also noted.

Daily summary
13th December 1995
Clinical notes – verbally aggressive, not mobilising, not eating. Hopeless and suicidal. (page 60/61)
Admission form – transferred to Mulberry Ward. Residential home could not cope. Verbally aggressive, lack of energy and self-motivation. (page 120)
Physical assessment – walks with aid of 2 nurses. Shuffles due to Parkinson's, frustrated and fed up. (page 121/122/123/124)
Nursing notes – admitted to Mulberry ward from Hazeldene Residential Home increasingly difficult to manage. Physically and verbally aggressive. (page 139)
14th December 1995
Specific events – found on toilet floor sitting on bottom. Said to have slipped. No apparent injury. (page 143)

15th December 1995
Clinical notes – fell yesterday evening. Back pain this morning. (page 62)
Nursing notes – very demanding and verbally abusive. (page 140)
18th December 1995
Nursing notes – unsteady on feet. Quiet afternoon. (page 140)
20th December 1995
Clinical notes Code A (page 62)
Nursing notes – small amount of diarrhoea. (page 141)
22nd December 1995
Clinical notes – diarrhoea x 1 this am. Chest infection encourage fluids. No solid food yet. (page 62)
Specific events – chest infection commenced on erthromycin. Nursed in bed. Diarrhoea ++. (page 143)
23rd December 1995
Specific events – poor diet intake but drinking well. **2 small broken areas on buttocks now nursed on spenco mattress.** Very red rash to back of both legs, **scrotum and inside thighs**. (page 143) Catheter inserted. (page 144)
24th December 1995
Nursing notes and evaluation – brighter good fluid intake. Catheter draining. Rash on back of legs. (page 135)
25th December 1995
Nursing notes and evaluation – **remains in bed – 2 hourly turns**. All sacral areas observed and dressing changed. (page 135)
Specific events – calling out all night. (page 144)
27th December 1995
Clinical notes – poorly, abusive. Catheterised end of last week. Seen by physio. (page 63)
Nursing notes and evaluation – blister noted on penis. (page 135)
Specific events – **drowsy, rousable** but refused medication. (page 145)
28th December 1995
Nursing notes and evaluation – cream applied blister on penis. (page 136)
Specific events – very chesty x-ray confirmed chest infection. Antibiotics prescribed. (page 145)
30th December 1995
Nursing notes and evaluation – **nursed on pegasus mattress**. (page 136)
31st December 1995
Nursing notes and evaluation – back redressed as wound quite sloughly. (page 136)
1st January 1996
Nursing notes and evaluation – penis cleaned. Small amount of fluid and diet taken. (page 136)
Nursing notes – remains very drowsy this afternoon. (page 142)

2nd January 1996
Clinical notes – remains poorly and lethargic. **Skin breaking down**. On pegasus bed. Very poorly not medical problems. Referred to Dr Lord. (page 64)
3rd January 1996
Clinical notes – poor food intake fluid ok. Deteriorating some breaks in skin. (page 64)
Nursing notes and evaluation – **not eating and drinking very well**. (page 136)
4th January 1996
Clinical notes – seen by Dr Lord. Barthel 0. Catheter bypassing. Ulceration of **left buttock and hip**. Hypoprotenanemia. Residential home can be given up for long stay bed at GWMH. (page 65)
Nursing notes and evaluation – dressing applied to sacral area. (page 136)
Specific events – Dr Lord happy to take to Dryad ward tomorrow. Cancel bed at Residential home. (page 145/146)
5th January 1996
Specific events – transferred to Dryad Ward. (page 145/146)
Transfer form – poor physical condition. Broken pressure areas on buttocks and hip. Catheterised. Broken skin on scrotum. Nursed on pegasus mattress. Poor fluid and diet intake. (page 10/11)
Summary – transfer to Dryad ward. Sore on right buttock which has granuflex on. Same left intact. Left dressing renewed. **Scrotum sore and broken.** Encourage food and fluids. (page 23)
7th January 1996
Summary – only taken limited food and fluids. (page 23)
9th January 1996
Clinical notes – increasing anxiety and agitation. ? sufficient diazepam ? need opiates. (page 12)
Summary – very sweaty. Complaining of generalised pain to be seen by Dr Barton. (page 23)
10th January 1996
Clinical notes – for TLC in view of poor quality. (page 12)
Summary – condition remains poor to **commence oramorph 4 hourly**. (page 23)
15th January 1996
Summary – **seen by Dr Barton syringe driver commenced with diamorphine 80mgs.** Daughter informed of deterioration. Unresponsive unable to take food and fluids. Syringe driver replaced with diamorphine 80mgs. (page 23/24)
16th January 1996
Summary – condition remains poor. Some agitation. Seen by Dr Barton syringe driver recharged with diamorphine 80mgs. Right ear blistered. Nursed on back and left side. Marking very easily. **Turn 1½-2 hourly**. (page 24)
17th January 1996
Summary – seen by Dr Barton remains tense and agitated. Chest very bubbly. Distressed on turning. Further deterioration appears more settled. Syringe driver running satisfactory. (page 25)

18th January 1996
Clinical notes – further deterioration. S/C analgesia continues. (page 13)
Summary – **Syringe driver recharged 120mg diamorphine**. Appears comfortable. (page 25)
19th January 1996
Summary – marked deterioration. Position changed strictly 2 hourly. All areas intact except small discoloured area of toe. Breathing very intermittent. Colour poor. **Syringe driver recharged with diamorphine 120mgs**. (page 26)
20th January 1996
Clinical notes – unsettled on **haloperidol in syringe driver**. (page 13)
Summary – family visited. Syringe driver **recharged 120mgs diamorphine**. (page 26)
21st January 1996
Clinical notes – much more settled. Quiet breathing. Not distressed. (page 13)
Summary – settled. Syringe driver running to time. **Recharged at 17.45 with diamorphine 120mgs.** (page 27)
22nd January 1996
Summary – poorly but very peaceful. **Syringe driver recharged with diamorphine 120mgs. (page 27)**
23rd January 1996
Summary – syringe driver recharged 120mgs diamorphine. Condition remains poor. Night – deteriorated died at 01.45am. Death verified by S/N Martin in presence of N/A Young. For cremation. (page 28)
24th January 1996
Clinical notes – death verified at 1.45am by S/N Martin in presence of N/A Young. (page 13)

Comment
The pressure area care for this frail man was very poor and rather late. He should have been admitted on to a Pegasus mattress to help to prevent more pressure damage, this plus 2 hourly turns. There seems to have been little attempt to ensure that Code A had adequate fluids in spite of eating and drinking being a topic of a care plan covering 2 pages.
The nurses have not displayed an acceptable level of knowledge about the medication that they were administering and the possible side effects. They continued to administer large doses of Diamorphine when Code A was probably toxic with a respiration rate of 6 per minute. (Normal is 16-20 per minute).
Although Code A was very ill it is difficult to understand why he was given an increase in the dosage of his medication. There is no evidence of a diagnosis or ant attempt to make one. The nurses did not appear to challenge the medical orders given when there were possible contra- indications. On 17th January there is evidence that a verbal order was made for medication to increase the dosage of Diamorphine from 80 mgms to 120 mgms and 60 mgms of Midazolam. (he was

noted to be unresponsive), the nurses should have challenged this request and should not have taken a verbal order for a controlled drug. The medication was not written up.

This act on the part of the nurses and their apparent lack of knowledge about medication and the rules surrounding its prescription and administration was so far below an acceptable standard that their acts of omission in this case probably contributed to his poor condition and shortened his life.

The nursing care generally for Code A for nutrition, skin care and medication was below an acceptable standard expected of competent nurses at this time.

Operation Rochester. **Clinical Team's Assessment Form**				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B			3B	
Unexplained by Illness				

6.76. BJC72 Helena Service

Code A Age: **99**

Date of Admission to GWMH: **3rd June 1997**
Date and time of Death: **03.45 hours on 5th June 1997**
Cause of Death:
Post Mortem:
Length of Stay: **3 days**

Mrs Lake's past medical history:-

- Profound deafness
- Non insulin dependent diabetic
- Congestive cardiac failure
- Confusion
- Gout
- Upper respiratory infection
- Scabies
- Cholecystectomy

Mrs Service was a widow. She lived in Willow Cottage Residential home. She had a nephew who was her power of attorney. Mrs Service was admitted to Queen Alexandra Hospital on 17th May 1997 as an emergency admission via her GP after her condition had deteriorated and the Residential home were no longer able to cope. She was admitted to Gosport War Memorial Hospital on 3rd June 1997 for continuing care.

On admission a barthel score of 0 was recorded as well as a Waterlow score of 30. Care plan commenced for catheterised, superficial grazing to buttocks, hygiene, constipation and to settle at night. A mouth assessment was also completed.

Daily summary
3rd June 1997

Code A

Code A

Comment

This frail elderly lady was admitted from Queen Alexandra Hospital for continuing care. I Code A score of 30. She warranted a nimbus or a Pegasus mattress and 2 hourly turns.

Code A

The nursing care was very poor on several counts.

Operation Rochester. **Clinical Team's Assessment Form**				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B			3B	
Unexplained by Illness				

6.76. BJC73 Code A

Date of Birth: Code A Age: **73**
Date of Admission to GWMH: **Continuing care for 5 years**
Date and time of Death: **15.30 hours on 8th October 1997**
Cause of Death:
Post Mortem:
Length of Stay:

Miss Brown's past medical history:-

Code A

Miss Brown lived with her elder sister on the ground floor of her house. She had

Code A

Daily summary
March 1993

Code A

Code A

ADDITIONAL REPORT BY:- IRENE WATERS RGN, RHV, LL.M., M.N. M.Sc.Public Health
SPECIALIST FIELD:- NURSING CARE
REPORT ON THE NURSING CARE AT GOSPORT WAR MEMORIAL HOSPITAL
ADDITIONAL 25 CASES AND REVIEW OF ADDITIONAL NOTES FOR 6 CASES.
INSTRUCTED BY:- HAMPSHIRE POLICE

Code A

Code A

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B		2B		
Unexplained by Illness				

6.77. BJC74 Harry Dumbleton

Date of Birth: Code A Age: 79
Date of Admission to GWMH: **25th May 1993**
Date and time of Death: **13.40 hours on 12th June 1993**
Cause of Death:
Post Mortem: Cremation
Length of Stay: **19 days**

Mr Dumbleton's past medical history:-

Code A

Mr Dumbleton came from Portsmouth. Mr Dumbleton was a retired maintenance fitter and lived with his wife in his own home. They had been married for 47 years and had 3 children. Code A

Code A

Code A

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Daily summary

Code A

page

Code A

Comment

Mr Dumbleton was admitted to GWMH for continuing care. H Code A

Code A

From the little information here in my opinion the nursing care was below an acceptable standard and the knowledge about administration of medication was below an acceptable level.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B		2B		
Unexplained by Illness				

6.78. BJC75 Wilfred Harrington

Date of Birth: Code A Age: **87**
Date of Admission to GWMH: **8th June 1993**
Date and time of Death: **15.00 hours on 21st July 1993**
Cause of Death:
Post Mortem: Cremation
Length of Stay: **32 days**

Mr Harrington's past medical history:-

Code A

Mr Harrington lived with his wife at home. They had a son. Mr Harrington was admitted to Gosport War Memorial Hospital for respite care on 8th June 1993 for a 2-week period.

Code A

Daily summary

Code A

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Code A

Comment

Code A

The nurses should have queried the dosage of Oramorph on 20th July 1995
This was below an acceptable standard of knowledge about administration and effects of controlled drugs for competent nurses at this time.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A		2A		
Unclear B				
Unexplained by Illness				

6.79. BJC 76 John Ritchie

6.80. BJC77 Code A

Date of Birth: Code A Age: **87**
Date of Admission to GWMH: **6th February 1995**
Date and time of Death: **04.30 hours on 12th February 1995**
Cause of Death:
Post Mortem: Cremation
Length of Stay: **6 days**

Mrs Code A s past medical history:-

Code A

Mrs Code A was a widow. She lived with her son at his home. She had a home help and private help was also employed. She was admitted to Gosport War Memorial Hospital on 6th February 1995 as an emergency admission. She was

Code A

Daily summary

Code A

Code A

Comment

Code A

In my opinion the nurses should have queried the dosage of diamorphine and their failure to do so displayed a level of knowledge which was below an acceptable standard.

Operation Rochester. **Clinical Team's Assessment Form**				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A				
Unclear B			←3B	
Unexplained by Illness				

6.81. BJC78 Mary Donaghue

Date of Birth: Code A Age: **66**
Date of Admission to GWMH: **16th May 1991**
Date and time of Death: **23.05 hours on 3rd August 1991**
Cause of Death:
Post Mortem: Burial
Length of Stay: **80 days**

Mrs Donaghue's past medical history:-

Code A

Mrs Donaghue was a widow. She lived on her own with her two daughters living nearby. Mrs Donaghue was admitted to the Royal Haslar Hospital with probable

Code A

Daily summary

15th May 1991

Code A

21st June 1991

Nursing notes excessively drowsy (page 79)

Code A

30th July 1991

Code A

Comment

Code A

Code A Her nursing care seems to have been appropriate and the notes, although brief, contain relevant information. There were no drug charts in the Bundle.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	1A			
Unclear B				
Unexplained by Illness				

6.82. BJC79 and JR07 Horace Rueban Smith

Date of Birth: Code A Age: **73**
Date of Admission to GWMH: **30th March 1999**
Date and time of Death: **01.02 hours on 6th April 1999 at Royal Haslar Hospital**
Cause of Death: **1 a) Acute Pancreatitis**
Post Mortem: yes
Length of Stay: **1 day**

Mr Smith's past medical history:-

Code A

Mr Smith was married and lived with his wife. They had two sons with one living in Ireland. Mr Smith was allergic to penicillin and was noted to be an alcoholic.

Code A

Whilst at Gosport War Memorial Hospital care plans commenced for hygiene,

Code A

Daily summary

30th March 1999

Code A

ss

Code A

Comment

Mr Smith was a very ill man, he was admitted to Royal Haslar Hospital with p
b
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Code A

The care given in that day appears to have been an acceptable standard.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	1A			
Unclear B				
Unexplained by Illness				

6.83. BJC80 Irene Brennan

Date of Birth: Code A Age: **87**
Date of Admission to GWMH: **10th June 1998**
Date and time of Death: **14.15 hours on 1st July 1998**
Cause of Death:
Post Mortem: cremation
Length of Stay: **21 days**

Mrs Brennan's past medical history:-

Code A

Mrs Brennan was a widow. She had two daughters and lived with one of her daughters. Mrs Brennan's daughter was becoming aware of Mrs Brennan increasing dependency and shared care was arranged for her. Mrs Brennan was

Code A

Code A

the help of two nurses and a hoist.

Daily summary
May 1998

Code A

Code A

Comment

Mrs Brennan was cared for at home. she lived with on of her daughters. She was admitted to GWMH a Code A

Code A

increased or changed to meet her needs and reasons were given in the nursing records on each occasion.

Operation Rochester. Clinical Team's Assessment Form				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A	1A			
Unclear B				
Unexplained by Illness				

6.84. BJC81 Code A

Date of Birth: Code A Age: **80**
Date of Admission to GWMH: **21st August 1995**
Date and time of Death: **17.25 hours on 8th February 1997**
Cause of Death:
Post Mortem:
Length of Stay: **1 year 171days**

Code A 's past medical history:-

Code A

Code A lived with her husband. They had a son and daughter. Code A was admitted to Gosport War Memorial Hospital on 21st August 1995 into a slow stream stroke bed.

Code A

Daily summary
21st August 1995

Code A

Code A

Summary seen by Dr Lord excess wax in ears Dr Barton to investigate (page

Code A

ADDITIONAL REPORT BY:- IRENE WATERS RGN, RHV, LL.M., M.N. M.Sc.Public Health
SPECIALIST FIELD:- NURSING CARE
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Code A

Code A

Code A

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Code A

Comment

This lady was admitted to Gosport War Memorial Hospital on 21st August 1995 from Haslar. She was to have rehabilitation. S

Code A

Code A

Code A

Operation Rochester. **Clinical Team's Assessment Form**				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A		2A		
Unclear B				
Unexplained by Illness				

6.85. BJC82 Olive Cresdee

Date of Birth: Code A Age: **69**
Date of Admission to GWMH: **3rd April 1990**
Date and time of Death: **15.30 hours on 2nd June 1990**
Cause of Death:
Post Mortem:
Length of Stay: **30 days**

Mrs Cresdee's past medical history:-

Code A

Mrs Cresdee was married and had three children. She lived with her husband in a

Code A

Daily summary
March 1990

Code A

Comment

There were no nursing notes for GWMH. There was no drugs chart.
I did not have enough information to form an opinion about the standard of care given to Mrs Cresdee but am sufficiently concerned about the family's concerned to say that the full notes should be recovered for review.

Operation Rochester. **Clinical Team's Assessment Form**				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A		?	?	
Unclear B		?	?	
Unexplained by Illness				

6.86. BJC83 Joan Hurnell

Date of Birth: Code A Age: **78**
Date of Admission to GWMH: **14th May 1999**
Date and time of Death: **07.31 hours on 18th May 1999**
Cause of Death:
Post Mortem:
Length of Stay: **5 days**

Mrs Hurnell's past medical history:-

- Code A

Mrs Hurnell was a widow. She had been married twice and had 2 children from her first marriage with whom she had no contact. She had 3 children from her second marriage, a son and 2 daughters. Her son lived with her Monday to Friday and one of her daughters visited at the weekends even though she was crippled with arthritis. Her other daughter lived in Northampton.

Code A

Code A

Daily summary

Code A

Code A

Comment

The pain relief in this case does not appear to have been adequate, the nurses should have queried this. Mrs Hurnell was suffering from breast cancer and possible cerebral secondaries.

She was in a side room. In my opinion Mrs Hurnell did not have a standard of care from the nurses which met her essential care needs.

Operation Rochester. **Clinical Team's Assessment Form**				
Care Death/Harm	Optimal 1	Sub Optimal 2	Negligent 3	Intend to Cause Harm 4
Natural A		2A		
Unclear B				
Unexplained by Illness				

The following cases have already been reviewed and additional records have been found. The next section is a comment on the additional records and if they caused the reviewer to revise the original opinion. The paragraph numbers are from the origibnal report where the notes were reviewed.

6.25. JR02/BJC22 Harry Hadley

Nothing further to add.

6.47. JR02/BJC44 Elizabeth Rogers

Nothing further to add.

6.09. JR03/BJC07 Stanley Carby

Nothing further to add.

6.49. JR04/BJC46 Jean Stevens

Haslar notes useful. Regular Diamorphine at Haslar. Changed from 3B to 2B.

6.61. JR06/BJC58 James Corke

Nothing further to add.

6.42. JR05/BJC39 Joan Ramsey.

7.00 Expert's statement of truth

I confirm that insofar as the facts stated in my report are within my own knowledge I have made clear which they are and I believe them to be true, and the opinions I have expressed represent my true and complete professional opinion.

Signature Code A Date 10th September 2004.

Irene Waters. LL.M., MSc. Public Health, Master of Nursing, RHV, RGN.